SCHOOL-BASED ASTHMA MANAGEMENT PLAN
Endorsed by the Michigan Asthma Steering Committee of the Michigan Department of Community Health

STUDENT INFORMATION
Child’s Name: ___________________________ Birth Date: _________________
Grade: ___________ Home Room Teacher: __________________________
Physical Education Days and Times: ________________________________

EMERGENCY INFORMATION
TO BE COMPLETED BY THE CHILD'S PARENT/GUARDIAN
Parent/Guardian Name(s): _________________________________________
________________________________________________________________
First Priority Contact: Name: ____________________________
Phone: ____________________________
Second Priority Contact: Name: ____________________________
Phone: ____________________________
Doctor’s Name: ____________________________ Phone: ____________________________

TO BE COMPLETED BY THE CHILD'S DOCTOR

WHAT TO DO IN AN ACUTE ASTHMA EPISODE:
1. 
2. 
3. 

CALL 911 OR AN AMBULANCE IF: Review attached “Signs of an Asthma Emergency” and list any additional symptoms the child may present with:

DAILY MANAGEMENT PLAN – TO BE COMPLETED BY THE CHILD'S DOCTOR
Child’s Name: _________________________

Be aware of the following asthma triggers: ___________________________________________

______________________________________________________________________________

Severe Allergies: __________________________________________________________________

MEDICATIONS TO BE GIVEN AT SCHOOL:

<table>
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<tr>
<th>NAME OF MEDICINE</th>
<th>DOSAGE</th>
<th>WHEN TO USE</th>
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Side effects to be reported to health care provider: _____________________________________

______________________________________________________________________________

Does this child have exercise-induced asthma?  Yes    No

☐ This child uses an inhaler before engaging in physical exercise and if wheezing during physical activity.

Activity Restrictions (e.g., staying indoors for recess, limited activity during physical education):

______________________________________________________________________________

______________________________________________________________________________

Please check all that apply:

☐ I have instructed this child in the proper way to use his/her inhaled medications. It is my professional opinion that this child should be allowed to carry and use that medication by him/herself.

☐ It is my professional opinion that this child should not carry his/her inhaled medications or epi-pen by him/herself.

☐ Please contact my office for instructions in the use of this nebulizer, metered-dose inhaler, and/or epi-pen.

☐ I have instructed this child in the proper use of a peak flow meter. His/her personal best peak flow is: __________.

Doctor’s Signature: ___________________________  Date: ___________________________

Parent/Guardian Signature(s): ___________________________  Date: ___________________________

________________________________  Date: ___________________________
SIGNS OF AN ASTHMA EMERGENCY

SEEK EMERGENCY CARE IF A CHILD EXPERIENCES ANY OF THE FOLLOWING:

- Child’s wheezing or coughing does not improve after taking medicine (15-20 minutes for most asthma medications).
- Child’s chest or neck is pulling in while struggling to breathe.
- Child has trouble walking or talking.
- Child stops playing and cannot start again.
- Child’s fingernails and/or lips turn blue or gray.
- Skin between child’s ribs sucks in when breathing.

Asthma is different for every person.
The “Asthma Emergency Signs” above represent general emergency situations as per the National Asthma Education and Prevention Program 1997 Expert Panel Report.

If you are at all uncertain of what to do in case of a breathing emergency…
CALL 911 AND THE CHILD’S PARENT/GUARDIAN